DOCUMENT RESUME

ED 303 740 CG 021 439

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TITLE Anorexia Nervosa: An Overview for the School Counselor.
PUB DATE 87
NOTE 10p.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Anorexia Nervosa; Elementary Secondary Education; *High Risk Persons; *Identification; *School Counselors

ABSTRACT

Anorexia nervosa is a serious eating disorder which affects thousands of people every year. Ninety-five percent of all anorexics are females with the peak age of onset between 14 and 18. While anorexics fit into no specific stereotype, high-risk candidates are often perfectionists and model children who exhibit self-doubt, high conformity, emotional control, inhibited interpersonal relationships, and lack of assertiveness. Danger signals of anorexia include not eating, depression, lack of motivation, reclusive behavior, irritability, excessive exercise, a change in academic standing, hyperactivity, and increased perfectionism. Other noticeable signs include thinning and drying of hair, cold sensitivity, dry skin, and brittle nails. Anorexics often try to hide their weight loss by wearing bulky clothes. While anorexia nervosa is a treatable disease, treatment can take years to complete. Counselors can implement a prevention program in the school. The elementary counselor can develop a program to build students' self-esteem and teach problem-solving skills. Secondary counselors can continue the self-esteem building activities. They can administer the Eating Disorder Instrument and use its results along with referrals and observations to begin individual and small-group counseling sessions for at-risk students. Counselors can also work with teachers and parents, make literature on anorexia available, and work with other staff members to develop curricula to prevent anorexia. Counselors, parents, teachers, administrators, and the medical community must work together to combat anorexia nervosa. (NB)

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Anorexia Nervosa: An Overview for the School Counselor

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

"You can never be too rich or too thin." (An advertisement for Skor, a toffee candy product by Hersney s)

Anorexia nervosa is a serious eating disorder which affects thousands of people, mostly young girls, every year. It and its sister disease bulimia have been called "the diseases of the 1980's" (Eisele, et al., 1986). A relatively new disease to the public, anorexia has been known in the medical community for three centuries. In 1689 Richard Morton, an English physician, recognized anorexia in his patients, calling it "nervous consumption." It was later identified as a clinical entity in the early 1870's by E. C. Lasegue, a French professor of medicine, and W. W. Bull, a London surgeon. In 1874 Gull coined the term "anorexia nervosa" -- Latin for "disturbed nerve force" (Editorial Research Reports, 1985).

Today, the American Psychiatric Association classifies anorexia nervosa as a mental disorder (Editorial Research Reports, 1985) which "interferes with the fulfillment of responsibilities to the self and to others because it produces an intense and irrational fear of becoming fat, an obsession with food and weight control, and a life-threatening weight loss" (Levine, 1987). With the severe weight loss can come bradycardia, hypotension, dehydration, skin abnormalities, hypothermia, and fluid and electrolyte abnormality (Muuss, 1985). Death, often from cardiac arrest, occurs in approximately three percent of the cases (Levine, 1987).

While anorexia has been detected in people as young as eight and as old as eighty (Editorial Research Reports, 1985), the at-risk group is usually

pubescent girls and young women under thirty; ninety-five percent of all anorexics are females (Muuss, 1985) with the peak age of onset between fourteen and eighteen. As many as three percent of all girls in the twelve to twenty age group will develop anorexia, the number increasing by about 10,000 per year (Levine, 1987).

Anorexics fit into no specific stereotype. There are, however, some tendencies. High risk candidates are often perfectionists and model children who "can be distinguished from control groups by self doubt, greater conformity, neurotic anxieties, control of emotions, inhibited interpersonal relationships, lack of assertiveness, and stimulus avoidance" (Muuss, 1985). According to one study, females with the disease often come from families where the mother is "overbearing and intrusive, while the father is often passive and peripheral" (Hendrick, 1984).

Anorexia has traditionally been associated with the privileged class. But since 1976 the number of anorexics from the upper and upper-middle classes has fallen from seventy-one to fifty-two percent with the rate increasing among the lower class. And the disease is expanding its territory beyond the social classes, also taking its victims from such diverse groups as older women and Blacks (Levine, 1987). One study suggested that girls who come from families where the father held a low-paying, non-professional job or where both biological parents were not in the home were at greater risk (Eisele, et al., 1986).

Anorexics send out their own radar of warning signals to show that they have the disease. These danger signals include "not eating, depression, lack of motivation, reclusive or withdrawn behavior, irritability, excessive

exercise, a change in academic standing, hyperactivity, and increased perfectionism. In addition to the loss of weight, other noticeable signs and symptoms include thinning and drying of hair, cold sensitivity, constipation, lowered reflexes, dry skin, brittle nails, and lanugo -- fine white hair on the skin" (Editorial Research Reports, 1985). The anorexics often try to hide their weight loss by wearing bulky clothes and by avoiding settings such as the beach or the pool where they might have to display their emaciated bodies.

Why victims acquire the disease is unknown. There are, however, five theories about the causes of anorexia nervosa. The social theory blames society with its constant emphasis on being "fit, petite, and slim." The psychosexual theory suggests that the disease is a young girl's defense against the responsibilities of sexual maturity. The family systems theory puts the blame on families which do not discuss problems or ways to solve them, the biological theory suggests that hypothalmic dysfunction causes the problem, and the psychobiologic regression hypothesis "asserts that once body weight drops below a critical level of inadequate nutrition, neuroendocrine functions are impaired, which reverses the developmental changes of puberty (Muuss, 1985).

Anorexia nervosa is a treatable disease, the treatment depending on the severity of the disease at the time of its detection. The intervention only works, however, if the clients realize they have a problem and wish to join in finding a solution (Muuss, 1985).

The treatment can come in many forms, physical and psychological. In severe cases patients can be hospitalized. Part of the treatment includes intravenous feeding or force feeding with a stomach pump, depending on the

patients' condition. Concurrent with hospitalization is psychotherapy and family counseling. Psychotherapy focuses on "eliminating the adolescents' incorrect, irrational, and self-defeating cognitions, attitudes, and beliefs about food, health, body image, and self-concept" (Muuss, 1985). Family therapy emphasizes the "family system rather than . . . the individual" (Hendrick, 1984), a system that "centers on changing the patterns of family interaction. The focus of the disorder turns from the anorexic to the idea of the dysfunctional family" (Editorial Research Reports, 1985).

Two new methods of therapy include the nurturant-authoritative psychotherapy and the feminist group theory. The nurturant-authoritative psychotherapy suggests that anorexics need "to learn to trust and lean on another person (the therapist), who can begin to help [them] want to gain physical and emotional health more than [they want] to be skinny." The feminist group therapy focuses on the clients' rejecting "cultural stereotypes of beauty and feminine 'success' that they have previously accepted and [beginning] to develop their own standards of physical and emotional achievement" (Hendrick, 1984).

Treatment is usually successful. But because this treatment can often take from three to five years to complete with occasional client relapses (Muuss, 1985), prevention seems to be the key to the problem. Such a prevention program can be implemented in the school through the coordinated efforts of the elementary, junior high, and high school counselors.

The elementary counselor can begin the prevention process by developing a specific and on-going program to build students' self-esteem (using such activities as DUSO from the American Guidance Service) and by teaching

problem-solving skills early in the potential anorexics' school careers. The elementary counselor can also begin the therapeutic bonding through individual counseling sessions (Hendrick, 1984).

The junior high and high school counselors have an especially important role because many cases of anorexia begin during these years. They should continue the self-esteem and problem-solving activities begun in elementary. They can also administer the Eating Disorder Instrument (EDI), "a self-report, multiscale measure designed to assess psychological and behavioral traits common in eating disorders" (Elsele, et al., 1986). Using the results of the EDI, plus referrals and observations, the counselors can begin individual and small-group sessions for the at-risk students. They cannot, however, help all their student-clients. Therefore, they should become familiar with community resources related to eating disorders so that they are prepared to refer clients in advanced stages of the disease to a specialist (Levine, 1987).

Together, the elementary, junior high, and high school counselors should be the guiding forces in working with adults who have either a direct interest or contact with anorexics. These counselors can conduct teacher in-service and parenting conferences, organize support groups for at-risk students and their parents, and make literature available about anorexia nervosa to staff and community. The counselors can also work with the staff members -- especially home economics, health, and physical education teachers -- to develop curricula which include information about exercising, eating properly, foods and their effects, dieting, obesity, and heredity. Sex education should also be emphasized since many problems arise from a child's difficulty making the transition into puberty (Levine, 1987).

Anorexia nervosa is a serious and growing problem for a significant and increasing number of young people in society. It may be one of the major diseases of the 1980's, but if it is to be left behind in the twentieth century when the twenty-first century begins, counselors must work in concert with parents, teachers, administrators, and the medical community to make necessary changes -- societal and psychological -- in order to help victims and potential victims of anorexia nervosa.

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